

## Authorization to Return to School

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

My child's medical professional indicates that it is safe for my child to return to school on the date below or when the conditions specified have been met.

Date to return to school: \_\_\_\_\_

Conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Medical Professional's Printed Name: \_\_\_\_\_